

Manulife China Bank Life Assurance Corporation
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: +632 8884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife-chinabank.com.ph

Email: phcustomercare@manulife.com

Attending Physician's Statement Major Disease/Critical Illness Loss of Speech

Pati	ient's Name	Loss of Speech							
Atte	ending Physician's Name	Address							
This	s section must be completed by a qualified and regist	tered physician at the expense of the claimant.							
bee		f certain contingent events associated with his/her health. A claim has To enable us to assess the claim, we would be grateful for your							
Α.	GENERAL INFORMATION								
1.	Are you the patient's usual medical doctor?	Yes No							
	If yes, over what period do your records extend to?								
	Start date/////	End date / / / / yyyy							
2.	When did the patient first consult you for this condition?	/////							
3.	Please state symptoms presented and date symptoms first appeared.								
	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)							
4.	What / Who is the source of this information? In your opinion what were the likely durations of the pati	ient's symptoms? Please provide reasons.							
5.	Did the patient consult any other doctors for these symp If yes, please provide details below.	otoms before he/she consulted you? Yes No							
	Name of Doctor	Name of Clinic/ Hospital and Address							

	se provide idii	details	of the diagn	osis				
ate of onset	dd	/	mm	/	ууууу	-		
c) Date of diagnosis	dd	/	mm	/	уууу	-		
lease provide the name an	d address of c	loctor a	nd clinic/ho	spital w	here the di	agnosis was	s first mad	le.
Name of Doctor				Name	of Clinic/	Hospital an	d Addres	SS
ć	ate of diagnosis ease provide the name an	ate of diagnosis dd ease provide the name and address of c	dd	dd mm ate of diagnosis dd mm dd mm ease provide the name and address of doctor and clinic/hos	ate of diagnosis ///// dd	ate of diagnosis / / /	ate of diagnosis / /	ate of diagnosis / /

Vas the patient admitted in the hospital	?	Yes	[No	
f yes, please state name & address of	f hospital				
,				e	Time
	Admitted				Discharged
Please describe the extent of Loss of Sp	peech.				
1	ryes, please state name & address of omplaint/sate of Admission	f yes, please state name & address of hospital omplaint/s ate of AdmissionTime	omplaint/sTimeDate of Admitted	ryes, please state name & address of hospital	omplaint/s

(b) Do you consider the Loss of Speech, total and irrecoverable loss of the ability to speak due to physical damage to the vocal cords?

		Yes No If yes, please provide basis for details.
	(c)	Had the loss of speech been established for a continuous period of twelve months? Yes No If yes, please provide basis for details.
	(d)	Is the loss of speech resulted from psychiatric related causes? Yes No If yes, please provide basis for details.
8.	Plea	ase provide details of current treatment provided.
9.	Wha	at is the prognosis?
10.	Plea	ase provide full details of tests and results which have been performed to establish the diagnosis of Loss of Speech, and ch copies of all relevant hospital reports, laboratory and test results.

F	Name of Doctor	Name of Clinic/ Ho	ospital and Address				
L							
N	MEDICAL HISTORY						
Н	las the patient previously suffered fr	om the condition specified above or any related	illnesses?				
		ing date of consultations, their resulting diagno	sis, the name and address of atten				
	Date of Consultation	Name of Doctor / Address	Diagnosis				
	Is there anything in the patient's medical history which would have increased the risk of Loss of Speech?						
ls	s there anything in the patient's med	ical history which would have increased the risk	of Loss of Speech?				
ls	s there anything in the patient's med	ical history which would have increased the risk	of Loss of Speech?				
lf	Yes yes, please provide details includ	·	agnosis, name and address of atter				
lf	Yes yes, please provide details includ	No ling the date of consultations, their resulting diagrams.	agnosis, name and address of atter				
lf	Yes f yes, please provide details includ loctor. Please state source of inform	No ing the date of consultations, their resulting diation.	agnosis, name and address of atter				
lf	Yes f yes, please provide details includ loctor. Please state source of inform	No ing the date of consultations, their resulting diation.	agnosis, name and address of atten				
Iff d	Yes f yes, please provide details includictor. Please state source of inform Date of Consultation Please give details of the patient's	No ing the date of consultations, their resulting diation.	Diagnosis Piagnosis Piagnosis e risk of Loss of Speech (including				
Iff d	Yes f yes, please provide details includictor. Please state source of inform Date of Consultation Please give details of the patient's	No ing the date of consultations, their resulting diation. Name of Doctor / Address family history which would have increased the	Diagnosis Piagnosis Piagnosis e risk of Loss of Speech (including				
Iff d	Yes f yes, please provide details includication. Please state source of inform Date of Consultation Please give details of the patient's elationship, nature of illness, date of	No ing the date of consultations, their resulting diation. Name of Doctor / Address family history which would have increased the	Diagnosis Prince Diagnosis e risk of Loss of Speech (including				
Iff d	Yes f yes, please provide details includication. Please state source of inform Date of Consultation Please give details of the patient's elationship, nature of illness, date of	No ing the date of consultations, their resulting diation. Name of Doctor / Address family history which would have increased the diagnosis) Please state source of information.	Diagnosis Prisk of Loss of Speech (including				

17.	Does the patient have or ever had any other significant health condition(s)?
	If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.
	ADDITIONAL INFORMATION
D.	ADDITIONAL INFORMATION
18.	Please provide us with any other additional information that will enable the Company to assess this claim.
l he	ereby certify that the above statements are true and complete to the best of my knowledge and belief.
	Name of Attending Physician (Please print) Degree/Specialty
	Signature Date Signed
	PRC Number / PTR Number Telephone Number (s)

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.